FORM APPROVED Division of Health Care Facilities (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 A. BUILDING B. WING 11/08/2010 TN1004 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1641 HIGHWAY 19E LIFE CARE CENTER OF ELIZABETHTON ELIZABETHTON, TN 37643 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 002 1200-8-6 No Deficiencies N 002 There were no life safety code deficiencies noted on the day of this annual licensure survey.

Division of Health Care Facilities

LABORATOR DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Executive Director

(X6) DATE